STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	COMPLETED	
		155377	1	LDING	00	05/04/2012
			B. WIN		ADDRESS SITY STATE ZIR CODE	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE	
OEVMOL	ID ODOOOINO				IACKSON PARK DR	
SEYMOL	JR CROSSING			SEYIVIC	DUR, IN 47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0000						
	This visit was for	r the Investigation of	F00	00	PREPARATION AND/OR	
	Complaint IN00	_			EXECUTION OF THIS PLAN	OF .
	Complaint 11100	100741.			CORRECTION IN GENERAL,	
	G 1 : DIOO:	10.0041			OR THIS CORRECTIVE ACTIVE	ON
	_	106941 - Substantiated.			IN PARTICULAR, DOES NOT	
		iciencies related to the			CONSTITUTE AN ADMISSION	ا ا
	allegations are ci	ted at F223, F225, F226.			OR AGREEMENT BY THIS	
					FACILITY OF THE FACTS	
	Survey dates: M	Tay 1, 2, 3, and 4, 2012			ALLEGED OR CONCLUSION	S
	Survey dates. 1914y 1, 2, 3, and 4, 2012				SET FORTH IN THIS	
	Facility number: 000272				STATEMENT OF	
					DEFICIENCIES. The plan of	
	Provider number				correction and specific	1
	AIM number: 10	00274710			corrective actions are prepar	
					and/or executed in compliant with state and federal laws.	ce
	Survey team:				The facility is requesting a	
	Janie Faulkner R	N TC			DESK REVIEW of compliance	
	Jill Ross RN				for this plan of correction.	
	3111 1CO35 1CTV				lor tino pian or correction.	
	C 1 14					
	Census bed type:					
	SNF/NF	73				
	Total	73				
	Census payor typ	oe:				
	Medicare	8				
	Medicaid	61				
	Other	4				
	Total	73				
	Sample: 5					
	These deficiencie	es also reflect state				
		accordance with 410 IAC				
	16.2.	accordance with 410 IAC				
	10.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

PRINTED: 06/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO A. BUILDING B. WING	00					
	PROVIDER OR SUPPLIE JR CROSSING	R	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE			
	Quality review 5	5/14/12 by Suzanne							

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Event ID: PYZV11

Facility ID: 000272

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	ETED
		155377	B. WING	d		05/04/	2012
				REET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ACKSON PARK DR		
SEVMOL	JR CROSSING				JR, IN 47274		
	TO ONO SOLINO			_ 110100	JIX, IIX 41214		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREF				COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
F0223 SS=E	483.13(b), 483.1 FREE FROM AB SECLUSION	3(b)(1)(i) BUSE/INVOLUNTARY					
	verbal, sexual, p	the right to be free from hysical, and mental abuse, nent, and involuntary					
	sexual, or physic	not use verbal, mental, al abuse, corporal nvoluntary seclusion.					
	Based on intervie	ew and record review, the	F0223				06/03/2012
	facility failed to	ensure the residents were					
		d verbal abuse. This					
		e affected 1 of 5 residents			F-223 Free from abuse/ involuntary		
	•	se in a sample of 5.			seclusion		
		•			The facility's intent is to maintain an		
	` ′	This deficient practice			environment free from abuse/		
	•	ntial to affect the 55			involuntary seclusion.		
		g on the A and B wings,			involuntary sectorion.		
	of the 73 residen	ts in the facility.					
	Findings include	d:			A. ACTIONS TAKEN:		
	complainant on 5 complainant indi ADON came in y	iew with the anonymous 5/1/2012 at 4:30 P.M., the cated the following, "The yelling at staff most every 1." "She yelled at me			Employees indicated were terminated.		
	multiple times, telling me that I wasn't getting all of my residents up for breakfast causing the day shift to fall behind."				B. OTHERS IDENTIFIED:		
					1. All residents have the		
	On 5/2/2012 at 1:15 A.M., an interview				potential to be affected.		
with LPN # 1 indicated the ADON was				Resident interviews completed	d		
	observed on 2/20	0/2012 screaming at			to ensure that they feel safe in their		
	•	<u> </u>			and the state of t		

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Event ID: PYZV11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155377	B. WINC			05/04/	2012
NAME OF P	PROVIDER OR SUPPLIEF	·			ADDRESS, CITY, STATE, ZIP CODE		
	JR CROSSING				ACKSON PARK DR DUR, IN 47274		
		TATEL CENTE OF POSTORES			OIN, IIN 47274		(77.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	,	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		Wing, and Resident # A			home as well as free from abuse.		
		"please [ADON's name]					
	don't yell, the girls have been working				3. In-service education		
		was on the phone talking			completed with department		
		the phone with her hand,			managers on appropriate employee	:	
		-			discipline on 5/15/12 by ED.		
	so that the family would not hear ADON yelling at staff." "I have gone to the				4. All staff in-service on, abuse		
	* *	•			prohibition, reporting, and		
		office, and the ADON			procedure as well as appropriate		
		told me to go take care			employee discipline scheduled on		
	_	no I didn't tell the			5/29/12 by ED or designee with a		
	Administrator."				post test.		
	stated, "Yes, I ha	:30 A.M., CNA # 3, ave heard ADON yelling earing distance of several			C. MEASURES TAKEN:		
	During an interv	iew with Resident # A on			All staff in-service on, abuse		
	_	A.M., the resident stated,			prohibition, reporting, and		
		rses don't have a good			procedure as well as appropriate		
		he residents." Resident #			employee discipline scheduled on		
		nere was anything that			5/29/12 by ED or designee with a		
	would make this	· -			post test.		
		sident # A replied, "get			2. Resident council meeting		
		itude nurse." Resident #			scheduled for 5/31/2012 to review		
		e has heard any nurse			reporting process of concerns to		
		es and he replied, "Yes, I			staff and will also be reviewed at		
		name] yell at aides and I			forthcoming resident council meetings.		
	_	use not yell at them; they			meetings.		
	•						
	had been workin	g naiu.					
	Housekeeper # 5	2:25 A.M., in an interview stated, "I have overheard ting loud in front of			D. HOW MONITORED:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155377	B. WIN			05/04/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				ACKSON PARK DR	
SEYMOL	JR CROSSING				OUR, IN 47274	
		TATEL OF DEPLOYED AND	1			avs)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE COMPLETION DATE
1710		<u> </u>		1710	Resident interviews will be	DATE
	residents, yes sup				completed to monitor for	
		upervisor yells at us too,			compliance. Also random employee	3
	_	istance of the residents."			interviews will be completed on all	
	"Housekeeping S	Supervisor tells staff to			shifts to ensure staff compliance and	d
	clock out and fin	ish their work as hours			understanding of abuse prohibition	
	cut and have to c	lock out by 2:00 P.M."			policy by the SSD/designee weekly	
	"I did go to [Adr	ninistrator's name] about			x4 then monthly x2 then quarterly	
		clock out and finish my			x3 to monitor for compliance and if	
		I'm not to do that; he			100% of threshold not met actions	
		supervisor." "No I did			plans will be developed.	
	1	•				
	not report the yel	ining to the			2. Abuse prohibition and	
	Administrator."				investigation, Abuse prohibition CQI	
					tool will be utilized by CEO/designed	
	During an interv	iew with Housekeeper#			weekly x4 then monthly x2 then	
	6 on 5/3/2012 at	9:35 A.M., the			quarterly x3 to monitor for compliance and if 100% of threshold	,
	Housekeeper stat	ted, "I have heard nursing			not met actions plans will be	'
	staff and supervi	sors talking loud in front			developed.	
	_	he Housekeeping				
		at staff within hearing			3. The Executive	
	1 1	esidents." "No, I did not			Director/Designee will monitor for	
		•			compliance of audits in the daily QA	
	report the yeming	g to the Administrator."			stand-up meeting.	
	0.5/4/2012	0.50 4.35 1 .				
		0:58 A.M., during a			4. All audit results will be	
		rview with LPN # 2, LPN			reviewed in the quarterly QA	
	stated, "I have	been threatened,			meeting with the Medical Director.	
	intimidated, and	yelled at by the ADON				
	and the DON." '	'On Martin Luther King				
	Day I was manda	ated to stay over four			E. This plan of correction	
	1	ON. I was down the hall			constitutes our credible allegation	
	1	d heard her yell down the			of compliance with all regulatory	
	1 ~	a heard her yen down the			requirements, out date of	
					completion is:	
		f she could, but that's all I				
		l you will stay." "The			6/3/12.	
	ADON was mad	all day. I was crying,				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL		
THEFTERN	or condition	155377		LDING		05/04/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30/0 !!	
NAME OF I	PROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOU	JR CROSSING				DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		told the unit coordinator."		TAG	Burelinery		DATE
	1	heard her yelling at two					
	1	ling them they didn't					
		were doing, and telling					
	<u> </u>	nall how terrible these					
	*	look." "[Resident # A]					
		o leave the girls alone;					
		the best they can and the					
	'	' "I agreed with [Resident					
		hat I'm supposed to					
	_	dministrator, but he's not					
		I didn't tell him."					
	approxemate, se						
	During an interv	iew with QMA # 4 on					
	5/4/2012 at 5:32	P.M., the QMA stated,					
	"Supervisors yel	l and curse at staff in the					
	presence of resid	lents." "I have seen an					
	increase in some	behaviors with some					
	residents." Revi	ew of Resident					
	Care/Need Sheet	under"MONITORED					
	BEHAVIORS,"	provided by the ADON					
	on 5/1/2012 at 10	0:45 P.M. for the B					
	_ ·	13 of 17 residents on this					
	hall were being r	nonitored for yelling,					
	cursing, screaming	ng, making derogatory					
	remarks, and hitt	ing others. Total					
		on the B Wing was 24					
		t out to a Behavior					
	Center.						
	Review of Resid	ent Care/Need Sheet for					
		cated 10 of 17 residents					
		ident/Care/Need Sheet					
		ORED BEHAVIORS"					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL 05/04/	ETED	
		155377	B. WIN			05/04/	2012
	PROVIDER OR SUPPLIER			707 S J	ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	UR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	were being moni screaming, makin hitting, and show residents living of the Administrate nurse were interved. 5:15 P.M., regard ADON, DON, and Supervisor yelling within hearing did the Administrator stated they were allegations. The "None of the staff Review of the "AREPORTING, APOLICY AND PEDUICY AND PEDU	tored for yelling, cursing, and derogatory remarks, ing others. Total on A Wing were 31. For and the corporate viewed, on 5/4/2012 at ding allegations of the and the Housekeeping ag at staff members stance of residents. Both or and the corporate nurse not aware of the Administrator stated, if reported this to me." ABUSE PROHIBITION, ND INVESTIGATION PROCEDURE" dated			CROSS-REFERENCED TO THE APPROPR	ATE	
	as the use of oral language that will disparaging and	"Verbal Abuse - defined , written, or gestured llfully includes derogatory terms to families, or within their					
		regardless of their age,					

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PRINTED: 06/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP. 05/04				
	ROVIDER OR SUPPLIER JR CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE			
	All abuse allegat	chend, or disability5. ions/abuse must be xecutive Director							
	This federal tag I IN00106941.	relates to complaint							
	3.1-27(a)(1) 3.1-27(b)								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUIL	DING	00	COMPLI 05/04/2	
		133377	B. WING		DDDEGG GETY GT ATT GDD	03/04//	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	IR CROSSING				OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
F0225 SS=E	483.13(c)(1)(ii)-(INVESTIGATE/F ALLEGATIONS/ The facility must have been found neglecting, or mi of law; or have h State nurse aide neglect, mistreat misappropriation any knowledge it law against an eindicate unfitnes or other facility s registry or licens. The facility must violations involvi abuse, including and misappropriareported immediathe facility and to with State law th procedures (includertification ager. The facility must alleged violations and must preven while the investig.	iii), (c)(2) - (4) REPORT INDIVIDUALS not employ individuals who I guilty of abusing, estreating residents by a court ad a finding entered into the registry concerning abuse, ement of residents or of their property; and report t has of actions by a court of mployee, which would s for service as a nurse aide taff to the State nurse aide ing authorities. ensure that all alleged ng mistreatment, neglect, or injuries of unknown source ation of resident property are ately to the administrator of other officials in accordance rough established uding to the State survey and		TAG			DATE
	officials in accord (including to the agency) within 5 and if the alleged	dance with State law State survey and certification working days of the incident, d violation is verified ective action must be taken.					
		ew and record review, the ensure allegations of	F022	25	F-225 Investigate/ report allegations/ individuals The facility's intent is to investigate.	l	06/03/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155377	B. WIN		-	05/04/	2012
		1			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			IACKSON PARK DR		
SEYMOU	JR CROSSING				DUR, IN 47274		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG			DATE
		ere immediately reported			report allegations/ individuals.		
	to the Administr	rator of the facility,			A. ACTIONS TAKEN: 1. Employees indicated were		
	reported to the s	tate agency, and			terminated. B. OTHERS		
	investigated. Th	nis deficient practice had			IDENTIFIED: 1. All residen	ts	
	the potential to a	affect 55 of 73 residents			have the potential to be affect		
	^	acility. (Residents on A			Resident interviews complete		
	and B Wings)	3 (to ensure that they feel safe in		
	and B ((ings)				their home as well as free from		
	Findings include	yd:			abuse. 3. In-service education	on	
	Tilldings illelude	cu.			completed with department managers on appropriate		
	5/2/2012	115 1 35			employee discipline on 5/15/1	2 bv	
		1:15 A.M., an interview			ED. 4. All staff in-service on,		
		dicated the ADON was			abuse prohibition, reporting, a	ınd	
	observed on 2/2	0/2012 screaming at			procedure as well as appropri		
	CNAs on the B	Wing, and Resident # A			employee discipline schedule		
	told the ADON,	"please [ADON's name]			5/29/12 by ED or designee wire post test. 5. Staff members		
	don't yell, the gi	rls have been working			report allegations of abuse	WIII	
		was on the phone talking			immediately to the ED/DNS a	nd	
		r the phone with her hand,			they will report allegations of		
		y would not hear ADON			abuse to ISDH after receiving	an	
		"I have gone to the			allegation of abuse. C.		
	1 -	_			MEASURES TAKEN: 1. A	II.	
		office, and the ADON			staff in-service on, abuse		
		I told me to go take care			prohibition, reporting, and procedure as well as appropri	ate	
		no I didn't tell the			employee discipline schedule		
	Administrator."				5/29/12 by ED or designee wi		
					post test. 2. ED/Designee to		
	On 5/2/2012 at 1	1:30 A.M., CNA # 3,			interview staff members on all		
	stated, "Yes, I h	ave heard ADON yelling			three shifts periodically to ens	ure	
		earing distance of several			understanding of abuse and		
	residents."				reporting requirements. D. HOW MONITORED : 1.		
					Resident interviews will be		
	On 5/3/2012 at 0	9:25 A.M., in an interview			completed to monitor for		
					compliance. Also random		
	_	stated, "I have overheard			employee interviews will be		
		king loud in front of			completed to ensure staff	_	
	residents, yes su	pervisors." "The			compliance and understanding	g of	

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Event ID: PYZV11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155377	B. WIN	G		05/04/2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	KO VIDEK OK GOTT EIEK				ACKSON PARK DR	
SEYMOL	JR CROSSING			SEYMC	OUR, IN 47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		upervisor yells at us too,			abuse prohibition policy by the SSD/designee weekly x4 then	
		stance of the residents."			monthly x2 then quarterly x3 to)
		Supervisor tells staff to			monitor for compliance and if	
		ish their work as hours			100% of threshold not met	
		lock out by 2:00 P.M."			actions plans will be developed 2. Abuse prohibition and	d.
	"	ninistrator's name] about			investigation, Abuse prohibition	n
		clock out and finish my			CQI tool will be utilized by	
		I'm not to do that; he			CEO/designee weekly x4 then	
	1	supervisor." "No I did			monthly x2 then quarterly x3 to)
	not report the yel	lling to the			monitor for compliance and if 100% of threshold not met	
	Administrator."				actions plans will be developed	d.
					3. The Executive	
	During an intervi	iew with Housekeeper#			Director/Designee will monitor	
	6 on 5/3/2012 at	9:35 A.M., the			compliance of audits in the dai QA stand-up meeting. 4. All	ly
	Housekeeper stat	ted, "I have heard nursing			audit results will be reviewed in	n
	staff and supervi	sors talking loud in front			the quarterly QA meeting with	
	of residents." "Tl	ne Housekeeping			Medical Director. E. This p	lan
	Supervisor yells	at staff within hearing			of correction constitutes our	
	distance of the re	esidents." "No, I did not			credible allegation of compliance with all regulator	.,
	report the yelling	to the Administrator."			requirements, out date of	y
					completion is: 6/3/12.	
	On 5/4/2012 at 1	0:58 A.M., during a				
	confidential inter	view with LPN # 2, LPN				
	stated, "I have	been threatened,				
	intimidated, and	yelled at by the ADON				
	and the DON." '	'On Martin Luther King				
	Day I was manda	ated to stay over four				
	hours by the AD	ON. I was down the hall				
	passing meds and	d heard her yell down the				
	hall that she wou	ld mandate me more				
	than four hours i	f she could, but that's all I				
	can give you and you will stay." "The					
		all day. I was crying,				
	mortified, and I t	old the unit coordinator."				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING B. WING			COMPLETED 05/04/2012	
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR JUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY ST	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
	"That same day I nurse's aides, tell know what they reveryone in the hadies [residents] told the ADON to they were doing a ladies look fine." # A]." "I know the report it to the Adapproachable, so During an intervity 5/4/2012 at 5:32." Supervisors yell presence of residincrease in some residents." Review Care/Need Sheet BEHAVIORS," I on 5/1/2012 at 10 Wing, indicated hall were being in cursing, screaming remarks, and hitt residents living owith one residents. Review of Resident Center. Review of Resident A Wing indicated in the Residents living owith one residents."	heard her yelling at two ing them they didn't were doing, and telling all how terrible these look." "[Resident # A] to leave the girls alone; the best they can and the "I agreed with [Resident that I'm supposed to diministrator, but he's not I didn't tell him." ew with QMA # 4 on P.M., the QMA stated, and curse at staff in the ents." "I have seen an behaviors with some ew of Resident under "MONITORED provided by the ADON 0:45 P.M. for the B 13 of 17 residents on this monitored for yelling, ag, making derogatory					

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Event ID: PYZV11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL		
11112 12111	or conditions	155377	A. BUILDING B. WING			05/04/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ACKSON PARK DR		
SEYMOUR CROSSING				SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ng derogatory remarks,		TAG	DIA (CILICET)		DATE
	_	ing others. Total					
	_	on A Wing were 31.					
	residents fiving (m 11 Wing were 31.					
	The Administrate	or and the corporate					
	nurse were interv	viewed, on 5/4/2012 at					
	5:15 P.M., regard	ding allegations of the					
		nd the Housekeeping					
		g at staff members					
		istance of residents. Both					
		r and the corporate nurse					
	stated they were						
	_	Administrator stated,					
	None of the star	ff reported this to me."					
	Review of the "A	ABUSE PROHIBITION,					
	REPORTING, A	ND INVESTIGATION					
	POLICY AND P	ROCEDURE" dated					
	February 2010, p	provided by the					
		1 5/3/2012 at 5:37 A.M.,					
		their current policy and					
	_	use. "It is the policy of					
		Communities to protect					
		buse including physical					
	· ·	use, verbal abuse, mental avoluntary seclusion, and					
	_	of resident property					
	and/or funds." "Verbal Abuse - defined as the use of oral, written, or gestured						
	language that wi	•					
		derogatory terms to					
		families, or within their					
		regardless of their age,					
	ability to compre	ehend, or disability5.					

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	of Correction identification number: 155377	A. BUILDING B. WING	00	COMP1 05/04	
	PROVIDER OR SUPPLIER JR CROSSING	STREET A 707 S J	ADDRESS, CITY, STATE, ZIP COD ACKSON PARK DR DUR, IN 47274	Е	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	All abuse allegations/abuse must be reported to the Executive Director immediately"				
	This federal tag relates to complaint IN00106941.				
	3.1-28(c) 3.1-28(d) 3.1-28(e)				
	3.1-20(e)				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X2)		(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPL	ETED
		155377 B. WING			05/04/2012		
NAME OF D	DOMBER OF CLIRRINE				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				707 S J	ACKSON PARK DR		
SEYMOUR CROSSING					OUR, IN 47274		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0226	483.13(c)	LSC IDENTIFY ING INFORMATION)		IAU	DEFICIENCE ()		DATE
SS=E	DEVELOP/IMPL ETC POLICIES	MENT ABUSE/NEGLECT,					
		develop and implement					
		nd procedures that prohibit glect, and abuse of					
		sappropriation of resident					
	property.						
	Based on intervie	ew and record review, the	F02	26			06/03/2012
		ensure their abuse			F-226 Develop/ implement abuse/		
	_	and procedure was			neglect, etc policies		
	1 1	ing the failure to ensure			The facility's intent is to develop/		
	allegations of ver				implement abuse/ neglect, etc		
	_	orted to the Administrator			policies.		
		ported to the state			A. ACTIONS TAKEN:		
		stigated. This deficient					
		potential to affect 55 of			1. Employees indicated were		
		ling in the facility.			terminated.		
	(Residents on A	•					
	(Residents on A	and b wings)			B. OTHERS IDENTIFIED:		
	Findings include	d:			1. All residents have the		
					potential to be affected.		
	On 5/2/2012 at 1	:15 A.M., an interview			Resident interviews complete to ensure that they feel safe in their		
	with LPN # 1 inc	licated the ADON was			home as well as free from abuse.		
	observed on 2/20	0/2012 screaming at			In-service education		
	CNAs on the B V	Wing, and Resident # A			completed with department		
	told the ADON,	"please [ADON's name]			managers on appropriate employee		
	don't yell, the gir	ls have been working			discipline on 5/15/12 by ED.		
	hard." "A nurse	was on the phone talking			4. All staff in-service on, abuse		
	and had to cover	the phone with her hand,			prohibition, reporting, and procedure as well as appropriate		
	so that the family	would not hear ADON			employee discipline scheduled on		
	yelling at staff."	"I have gone to the			5/29/12 by ED or designee with a		
		office, and the ADON			post test.		
		told me to go take care			5. Staff members will report		
		no I didn't tell the			allegations of abuse immediately to		
	5, 50				the ED/DNS and they will report		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED		
		155377	B. WING			05/04/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
SEYMOUR CROSSING			707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL						
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·	DATE	
	Administrator."				allegations of abuse to ISDH after		
					receiving an allegation of abuse.		
	On 5/2/2012 at 1	:30 A.M., CNA # 3,					
	stated, "Yes, I ha	we heard ADON yelling			C MEACHINES TAKEN		
		aring distance of several			C. MEASURES TAKEN:		
	residents."				All staff in-service on, abuse		
	Tobladins.				prohibition, reporting, and		
	On 5/2/2012 at 0	:25 A.M., in an interview			procedure as well as appropriate		
					employee discipline scheduled on		
	•	stated, "I have overheard			5/29/12 by ED or designee with a		
	_	ing loud in front of			post test.		
	residents, yes suj	pervisors." "The			2. Abuse prohibition and		
	Housekeeping St	upervisor yells at us too,			investigation in-services are held		
	within hearing di	stance of the residents."			during orientation and no less than		
	"Housekeeping S	Supervisor tells staff to			4 times per year. In-service to be		
		ish their work as hours			conducted by ED or designee.		
		lock out by 2:00 P.M."					
		ninistrator's name] about					
		-			D. HOW MONITORED :		
	_	clock out and finish my			Resident interviews will be		
		I'm not to do that; he			Resident interviews will be completed to monitor for		
	1	supervisor." "No I did			compliance. Also random employee		
	not report the yel	lling to the			interviews will be completed to	•	
	Administrator."				ensure staff compliance and		
					understanding of abuse prohibition		
	During an interv	iew with Housekeeper#			policy by the SSD/designee weekly		
	6 on 5/3/2012 at	•			x4 then monthly x2 then quarterly		
		ted, "I have heard nursing			x3 to monitor for compliance and if		
		sors talking loud in front			100% of threshold not met actions		
	•	•			plans will be developed.		
	of residents." "The Housekeeping				2. Abuse prohibition and		
		at staff within hearing			investigation, Abuse prohibition CQI		
		esidents." "No, I did not			tool will be utilized by CEO/designed	<u> </u>	
	report the yelling	g to the Administrator."			weekly x4 then monthly x2 then		
					quarterly x3 to monitor for		
	On 5/4/2012 at 1	0:58 A.M., during a			compliance and if 100% of threshold	1	
		rview with LPN # 2, LPN			not met actions plans will be		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE S		
		A. BUI	LDING	00	COMPLE		
		155377	B. WIN			05/04/2	2012
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>			ADDRESS, CITY, STATE, ZIP CODE		
			707 S JACKSON PARK DR				
SEYMOU	JR CROSSING			SEYMC	DUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		, , , , , , , , , , , , , , , , , , ,	+	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
	stated, "I have	*			developed. 3. The Executive		
		yelled at by the ADON			Director/Designee will monitor for		
		'On Martin Luther King			compliance of audits in the daily QA	١	
	_	ated to stay over four			stand-up meeting.		
		ON. I was down the hall			4. All audit results will be		
	ı ^	d heard her yell down the			reviewed in the quarterly QA		
		ald mandate me more			meeting with the Medical Director.		
		f she could, but that's all I			E. This plan of correction		
		l you will stay." "The			constitutes our credible allegation		
		all day. I was crying,			of compliance with all regulatory		
		told the unit coordinator."			requirements, out date of		
	"That same day l	heard her yelling at two			completion is:		
	nurse's aides, tell	ling them they didn't			6/3/12.		
	know what they	were doing, and telling					
	everyone in the l	nall how terrible these					
	ladies [residents]	look." "[Resident # A]					
	told the ADON t	o leave the girls alone;					
	they were doing	the best they can and the					
	ladies look fine.'	"I agreed with [Resident					
	# A]." "I know t	hat I'm supposed to					
	report it to the A	dministrator, but he's not					
	approachable, so	I didn't tell him."					
	During an interv	iew with QMA # 4 on					
	5/4/2012 at 5:32	P.M., the QMA stated,					
		l and curse at staff in the					
		lents." "I have seen an					
	1 ^	behaviors with some					
	residents." Revi	ew of Resident					
	Care/Need Sheet	under "MONITORED					
		provided by the ADON					
		0:45 P.M. for the B					
		13 of 17 residents on this					
	_ ·	nonitored for yelling,					
	1		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				ETED
		155377	A. BUI B. WIN			05/04/	2012
		<u> </u>	p. (/1.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ACKSON PARK DR		
SEYMOUR CROSSING					OUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	1	ng, making derogatory					
	•	ting others. Total					
	_	on the B Wing was 24					
	with one residen	t out to a Behavior					
	Center.						
	Review of Resid	lent Care/Need Sheet for					
	the A Wing indi	cated 10 of 17 residents					
		sident/Care/Need Sheet					
		ORED BEHAVIORS"					
		itored for yelling, cursing,					
		ng derogatory remarks,					
		ring others. Total					
	_	on A Wing were 31.					
	residents fiving (on A wing were 31.					
	The Administrat	or and the corporate					
		viewed, on 5/4/2012 at					
		ding allegations of the					
		nd the Housekeeping					
		ng at staff members					
		istance of residents. Both					
	_	or and the corporate nurse					
		not aware of the					
	1						
	allegations. The Administrator stated, "None of the staff reported this to me." Review of the "ABUSE PROHIBITION, REPORTING, AND INVESTIGATION POLICY AND PROCEDURE" dated February 2010, provided by the Administrator on 5/3/2012 at 5:37 A.M.,						
		their current policy and					
	-	ouse. "It is the policy of					
	American Senio	r Communities to protect					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155377	LDING	00 	COMPL 05/04	ETED		
	PROVIDER OR SUPPLIER JR CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	abuse, sexual abuse, neglect, ir misappropriation and/or funds." as the use of oral language that wildisparaging and residents or their hearing distance, ability to compre All abuse allegat reported to the E immediately"	buse including physical use, verbal abuse, mental avoluntary seclusion, and a of resident property "Verbal Abuse - defined , written, or gestured llfully includes derogatory terms to families, or within their regardless of their age, shend, or disability5. ions/abuse must be executive Director relates to complaint						

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Event ID: PYZV11

Facility ID: 000272

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